Mad in America
SCIENCE, PSYCHIATRY AND SOCIAL JUSTICE

Rodrigo Nardi is a psychiatrist and psychologist. He obtained his psychology degree in the year 2000, and following that, he obtained a certificate in CBT, and a Master's Degree in Clinical Psychology at Universidade Evangélica de Paraná. He obtained his M.D. degree in 2010, and in 2016, he completed his psychiatry residency at Penn State. Altogether, Dr. Nardi has worked as a Mental Health Professional for more than 20 years, covering from individual psychotherapy to inpatient and outpatient psychiatry, substance use treatment, and interventional psychiatry. His passion for teaching and learning has led to the creation of the True Psychiatry Network and the development of a mentoring program designed to address the most frequent challenges related to psychiatric training.

The transcript below has been edited for length and clarity. Listen to the audio of the interview here.

Brooke Siem: You have a circuitous route to becoming a psychiatrist. Can you tell us how you ended up in the field?

Rodrigo Nardi: Once you start studying psychology, it doesn't leave you. Brazil has a different system. It's more like the European system. In Brazil, psychology is a full grad school program. It's five years of study and in the last year, you work as a psychologist under supervision. Medical school is six years and during the last one to two years, you work as a doctor under supervision. Before I finished my Master's in psychology, I said, "Okay, I think I'm going to go to medical school" and I started all over.

When I was in medical school, I was an associate professor teaching psychotherapy techniques to post-graduates. I thought I might specialize in oncology, but every year, we would have to do data

collection as a team and I would tell my colleagues, "I'll take care of it." I was older than my colleagues and used to collecting data so it was effortless for me. I liked the behavioral-based questions and eventually realized I couldn't get rid of this psychology thing. Once you connect with the school of thought in psychology, your view of the world changes for good.

So when it came to choosing a residency, I applied for psychiatry and was lucky enough to get a position. Despite the limitations we have and the excesses of the field, it's a beautiful career. It's a lot of fun.

Siem: Given your background in psychology, what was your mentality going into the psychiatry arm of medicine at that time?

Nardi: Because I was a psychologist, the biochemical hypothesis never made any sense to me. If you read any author in psychology, that argument will die. Even if I can entertain the idea that maybe one in 1,000 people who with low mood could have a some biological issue, I never bought into the theory. But going to residency is a very humbling experience.

Imagine that you're a black belt in karate, and you're going to start Jiu-Jitsu. Suddenly, you're a white belt again and nobody's going to listen to you. I wasn't a black belt in psychology—my development as a therapist is ongoing because it's a very long art.

When I entered into psychiatry, I was faced with this data saying that psychiatric drugs do something. I thought I could manage to live with this division in my head, even though it didn't make too much sense and it was difficult for me.

Everybody knows [in medicine], of the influence of pharma, on the training, on the textbooks, on the overall paradigm of psychiatry. People gravitate towards thinking of research questions that could get you a grant with pharma companies. It didn't occur to me that I was blind like everybody else.

I'm a big fan of human beings. I think we are the most amazing thing walking on earth. But I think I was also naïve. Now, I believe in the integrity of the process [of being human], and I would come to that a few years later.

Siem: I was listening to an episode of your podcast, the True Psychiatry, and you said that when you're going through med school and residency, you don't really have time to be a critical thinker when it comes to the information you're receiving. That was such a light-bulb moment for me because I keep wondering why so many doctors off course. I think this is part of the answer. Can you talk more about what it's like to be a psychiatric resident how that is influencing the situation we find ourselves in today?

Nardi: Medical school and residency are a compliance task. If you go through medical school and decide to question everything you see in front of you, not the emotional impact will prevent you from learning. Psychological training in Brazil, for example, is different from the American training. We still have the behaviorists making fun of the Freudians who will make fun of some other clique, and that is an important learning experience because the Freudian is going to look at you and present a criticism and you have think through that criticism. This makes psychology in Brazil a very strong science and art. We have wonderful thinkers. Every average psychologist can sit and give you a class on something

immediately that will be at a post grad level.

What this taught me is that if you don't have an emotional affiliation to what you're learning, your retention and understanding is limited. When you take that concept and apply it to medical school, if you don't embrace what you're reading, if you don't comply with it, you will struggle. There is no time to look into all these things and question every bit of them.

Medical school is basic until you get into the specialties. Then you get into residency and have a set system based on a paradigm that is heavily biased and you're given a limited amount of time to learn when you need to know. You cannot go in front of an attending doctor, question the method, and say, "If I suppress the negative emotions of this patient with drugs, what motivation will this patient have to address his own reality?"

So I left training as a heavy guideline kind of a guy. I was still blind to the absurd amount of bias we had. That became very clear later and triggered my quest for an alternative paradigm of psychiatry that could survive in our society.

Siem: What did your practice look like after your residency ended?

Nardi: My first job was inpatient psychiatry. I was seeing excessive medication regimens that didn't make any sense but I was telling myself was it was okay because it was inpatient psychiatry. I pushed away thoughts like, "What's the point of giving a drug to solve a quality of life problem?" But I kept pushing and playing cognitive tricks.

From there, I went to substance abuse. I started to see all these patients talking about staying sober but being chronically prescribed Adderall chronically, benzodiazepines, gabapentin. That's when I realized there was something wrong. I would have patients come to me and say, "Rod, please let me see you because Dr. So and So prescribes the same thing to everyone." It was like everybody had ADHD, everybody had generalized anxiety, so everybody ended up on the same drugs even though they were supposed to be staying clean. I became so displeased because when you're in the outpatient setting, you are inheriting cases, and I started to feel like my profession sucked.

At first, I thought if we embraced guidelines, the excesses prescriptions would go away. I was still blind. But it but then I started to look deeper and I found literature from critical psychiatry, from Mad In America, and I started to learn from these folks. For me, it was like a shock. And then I said oh my God, how come I didn't see this before?

Siem: How did you find the work of Robert Whitaker?

Nardi: Whitaker and Ron Bassman's experience with psychosis and the system back in the 1960s and 1970s helped everything fall in place for me. I felt terribly anxious and angry for being blind. Then I really started to dive deep in the hole.

Siem: When this transition was happening for you, what was your relationships with your colleagues like at the time, and how did that start to change?

Nardi: I remember a director telling me one day. He said, "You have a fiduciary duty to your patient. Even if your employer is a place that takes Medicare or Medicaid money, that's tax money."

Brooke Siem: What do you mean by "fiduciary duty to your patient"?

Nardi: It means you serve the person who is paying you. You don't serve the hospital. You don't serve the clinic that hired you. You don't serve the CEO. You serve the patient.

Siem: You don't serve the pharmaceutical company who might be paying you on the side.

Nardi: Perfect, right.

Siem: What makes you different? Why were you willing to go toward the discomfort whereas so many other folks in the field seem to go immediately to defense?

Nardi: I wish I could say I'm like some sort of Messiah, but if you like what you do—and I do love it—you don't want to see corrupted. I have seen psychiatric nurses quit, after all the training, and go back to a registered nurse profession because they could not live with what they were forced to do. In a sense, [my transformation] was selfish. I said to myself, "If I can develop a way to work that brings me more satisfaction, if I can develop a paradigm that can survive considering the legalities, I think my life is going to be better."

Siem: What is the current standard of care in psychiatry? And how are you making sure you're meeting standard of care requirements while operating in this alternative paradigm?

Nardi: Because of the significant risk of litigation, doctors are afraid of doing anything differently. In psychiatry, informed consent is really not performed. For example, I asked my colleagues, "If you were an insomniac, anxious, or depressed, would you take the anti-psychotic Seroquel, with all the side effects that come with it?" Not once did someone say, yes. My next question was, "Then why are your patients taking Seroquel when you offer it to them?" The answer is because an informed consent is not being done.

I'm not saying you should look at your patient and say, "Hey, I'm going to offer you this med because this is what my training is about. But I wouldn't take because of the side effects." You don't have to put those words. You tell them medication is an option *and* discuss what are the expected side effects—the ones *you* would think about before taking a pill.

To have informed consent, the patient needs to have a fair amount of information. When you give that information with *any* of the drugs, you start noticing that about 8 or 9 out of 10 patients wait another month.

I have a lot of patients that come to me—especially male—who say, they have a problem with anger. I look for basic emotional needs based in Freud, Maslow, Seligman, and evolutionary psychology and explain [to the patient] that they are linked to survival. One of these basic emotional needs is to have relationships. What I find is that people are terribly deprived of different basic emotional needs that come right after, in terms of relevance, to the physiological needs. There's no point in talking about your mother in therapy before we address your solitude, before we address the fact that you have no accomplishments, before we address the fact that human beings need novelty. Anxiety and anger, for example, is both endogenous and exogenous. It's both a reaction to the environment but it also comes from the organism itself, just like sexual arousal. Anxiety and anger add to your capacity to survive, so anticipating threats and reacting to the absence of those threats should be built in our biological

system.

I address these things [to the patient] and present my "diagnosis." I still use the DSM because I need to pay my bills and I cannot send a diagnosis to an insurance company and say, "This patient is deprived of accomplishments, purpose, and social interactions." So I say whatever DSM-ish form it takes but and I tell the patient, "It's not something you have. It's just a name I'm giving to this thing. What you are struggling with is very basic things needed to have a decent life."

Siem: That in itself—just informing your patient that what you're writing down is a name for a cluster of symptoms rather than a diagnosis—is a radically different strategy than telling someone the meet the criteria for Borderline Personality Disorder or bipolar. It's a basic shift of perspective that can literally change a person's life.

Nardi: And it doesn't take too much more time than talking about drugs, but it's so welcomed by patients. You start seeing patients say I want you to see my sister, I want you to see my neighbor, and they start sending you referrals. It's resonating with people. We are ripe for a change. And from a legal perspective, I'm just following the same rules in my textbooks. I'm performing actual informed consent.

I was recently interviewing Robert Haim Belmaker and Pesach Lichtenberg. They just published what I believe is the most important psychopharmaceutical book of our time. One of the things I said to them was that I can define my paradigm in front of a judge. Dr. Belmaker said that was one of the motivations for the book. Now you can show a judge [Belmaker's work] and say this guy with this CV wrote this book about psychopharm that says this is what we can and cannot do.

Psychology has multiple paradigms, so it makes no sense that psychiatry doesn't have alternative paradigms of work. Emotions are our sixth sense, right? What is the biological program that tells you to run if you see a grizzly bear, which is useless because he's going to catch you anyway? It's not just the sight of the bear. It is not just the smell of it. It's the emotional reaction that your body gives you that says, *run.* Negative emotions have a role trying to tell you something about your reality. Just like tight shoes will make your feet hurt, that doesn't mean your body is sick. Your body works exactly as it should—

Siem: We don't need a pill to make our feet smaller. Just need different shoes.

Nardi: Exactly. But here's the beauty of it. Let's say you ordered those shoes, they took forever to arrive, and they're just fabulous. You don't want to return them. You say, "I'm going to wear them for the party. I looked too good in them. I want to use them." What do you do is you take a pill to suppress the pain or you have a few shots of tequila. This is desirable impairment. I don't rule out the possibility of a desirable impairment to suppresses emotions, but in general, changing the shoes, is a smarter idea. The feelings you have deserve to be felt one way or another. I tell my mentees and the people I work with that if you suppress these emotions [with drugs], there's a very good chance that not only are you inducing stagnation, but that I suspect emotion is going to come back later for you. There's learning negative emotion. This may be what pushes you towards activity, connections, socialization, a new career.

Part of my dedication to psychiatry is the fact that my son lives in another country and I miss him

terribly. I have to find a meaning to his absence. So I use all this extra time that I have to make a sense of things and try to do something meaningful. I what to be able to put my head in the pillow and when I am 80, look back and know I was not part of the problem.

Siem: Your nonprofit, the New England Psychiatry Mentorship Institute, is fairly new. Where do you hope this goes in the next three to five years?

Nardi: The mentorship is a sort of a cooperative network. I teach the paradigm, but it allows for your artistic expression, so to speak, because that's what I believe psychotherapy is. It's financially sustainable, and it can be done in a way that is legally safe [for the clinician] and safer for patients than the excesses that psychiatry permits. When I started this thing, and I thought the challenge would be to get people to be a part of it. It turns out that's not going to be the case. From a patient's perspective, it's not a challenge anymore. There's more people looking for something meaningful that celebrates what a human being *is* versus, "Here's the pill you take to stay put and keep living the life you're living." People are ready. What I expect is that doctors will join this cooperative and they will find a profession that is as gratifying as I find it now.

People are reaching out to me to join, but the task is teaching. It's difficult teach the paradigm because it contrasts with years of training but it's doable and I'm doing it. My hope is that folks will have a lot of fun, feel they're actually helping people without hurting them, and that they will contribute. They'll say, "I disagree with you, and I have this idea. How do you think this style of practice fits here?"

Now I'm not smart enough to be compared to a guy like Freud. But Freud had Jung disagreeing with him in real time, coming up with amazing contributions that Freud didn't. And Freud is freaking amazing. So what I'm hoping is that people disagree and come up with [their own] paradigm. I believe in one truth, but the truth is so complex and so layered that we don't ever reach the truth. Truth for us is a path towards truth, and some of us make a life out of that path towards truth.

So I expect being confronted and questioned and learn because the human experience is way too rich to be reduced to this thing we have been reducing it to. Human things are absolutely amazing. We are capable of unspeakable things and there's much more room for positivity than anything else in our existence. My hope is that it causes enough noise that I can learn more from it, and that people join and say, "I'm having fun with my profession."

Siem: Last question. What would you say to a young psychiatrist who's just getting out of residency, who is questioning some of what they've been taught, but is too scared to express what they're feeling? What would you say to a young doctor today?

Nardi: Don't let the feeling die. You may be the next big step towards a better psychiatry. Accept the fact that human beings are too complex to fit uniformly simple models. Even though I believe we need simple models to replace the one we have, or rather we have alternative paradigms that are simple enough to be taught. But don't quit on that feeling.

However, learn the legalities. Learn the relationship between psychiatry and the law because once you are strong in that position, you can say, "All right, I'm going this direction, and I'm going safely in that direction." I would not advise anyone to ruin their career on account of that kind of [legal] pressure. If you need to fall back to standard, you fall back to standard. Do not sacrifice your career because you

need to live to fight another day. But good things are coming. Great changes are coming. We have hallmark publications like the Maudsley Deprescribing Guidelines. We have Bill Macher and Lichtenburg's book. W have the fact that I've been practicing psychiatry in a completely different way, and my phone isn't ringing with threats or anything like that. It's a changing, exciting time, and we will be a field that is as rich as psychology used to be. It's unavoidable because the truth always makes itself noticed.

Siem: Where can people find you if they want to reach out?

Nardi: They could find me at True Psychiatry Network. You're going to find an email there. You're going to find a phone number. You can call, leave a message, text. Do whatever you want to do to discuss ideas or to talk on my podcast. To join the network, the only limitation for people joining is the finances involved in it. It has a cost until it become self sustainable.

Siem: Dr. Nardi, thank you so much for being here with us and for sharing your new paradigm and helping move this world forward. I know people like me really appreciate it. I'm glad you're doing the work.

Nardi: I appreciate you. It's very good to see you again, Brooke.

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Brooke Siem

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